APPEAL NO. 052449
FILED DECEMBER 29, 2005

This appeal arises pursuant to Texas Workers' Compensation Act. TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on September 30, 2005. The disputed issues were:

1. Does the compensable injury of _____, extend to and include chronic pain syndrome, disc herniation at L5/S1 and lumbar radiculopathy/paresthesias?

2. Has [respondent (Carrier)] waived the right to dispute compensability of disc herniation at L5/S1 and lumbar radiculopathy/paresthesias by not timely contesting the diagnosis in accordance with Texas Labor Code Section 409.021 and 409.022?

3. Is [appellant (Claimant)] entitled to reimbursement of travel expenses for medical treatment at the direction of [Dr. R] and [for travel expenses to PRIDE, (subclaimant) and] if so, in what amount?

4. Did the first certification of Maximum Medical Improvement [MMI] and Impairment rating [IR] assigned by [Dr. M] on May 11, 2004, become final under 28 TEX. ADMIN. CODE § 130.12 (Rule 130.12)?

5. Has the Claimant reached [MMI] and, if so, on what date?

The hearing officer determined that the compensable injury does not extend to and include chronic pain syndrome, disc herniation at L5/S1 and lumbar radiculopathy/paresthesias, that the carrier did not waive the right to dispute compensability of the disc herniation at L5/S1 and lumbar radiculopathy/paresthesias, that the claimant is not entitled to reimbursement for travel expenses for medical treatment by Dr. R or the subclaimant, that the first certification of MMI and IR assigned by Dr. M did not become final under Rule 130.12 and that the claimant reached MMI on May 11, 2004.

The claimant and subclaimant appeal the extent of injury, waiver, travel expense and MMI issues, contending that the hearing officer erred in identifying Dr. M as the designated doctor, that (Dr. MC) was the designated doctor and his opinion that the claimant was not at MMI (in February 2004) and would reach MMI on or about June 1, 2004, had presumptive weight, and that the carrier, by preauthorizing treatment for the chronic pain syndrome admitted the treatment was reasonable and necessary. The subclaimant contends had it been put on notice that compensability on the extent of the injury was being disputed it would not have provided treatment. The claimant/subclaimant do not appeal the Rule 130.12 finality issue and that determination has become final pursuant to Section 410.169.

The carrier responds, asserting that the characterization of Dr. M as the designated doctor was "nothing more than a clerical error" and that the hearing officer's determinations on extent of injury, mileage, carrier waiver and MMI should be affirmed.

DECISION

Affirmed in part and reversed and remanded in part.

The parties stipulated that the claimant sustained a compensable injury on _____. It appears undisputed that the claimant sustained a low back injury in a motor vehicle accident when his weight shifted and he was thrown against the seat belt. The hearing officer also stated that the parties stipulated that:

4. Claimant has been certified with an [IR] of 5% by [Dr. M], the properly appointed Designated Doctor in this case.

That statement is clearly incorrect and not supported by the evidence.[1] When the hearing officer proposed that stipulation, both parties protested and agreed that Dr. M was not the designated doctor and that Dr. MC was in fact the designated doctor (TR page 9). The carrier represented that Dr. M was the carrier's required medical examination (RME) doctor. The hearing officer replied "OK [MC], he's the properly-assigned designated doctor." Later the hearing officer summarizes the stipulations as "Venue, employer, compensable injury, five percent by [Dr. M] and [MC] is properly-appointed D.D."

The claimant apparently saw his first treating doctor on July 21, 2003 (those records are not in evidence) and was treated conservatively with physical therapy (which apparently made his condition worse). An MRI performed on August 18, 2003, showed a "posterocentral broad-based protrusion L5-S1 measuring 3-mm with high intensity signal zone suggesting annular tear/fissure with no significant nerve root contact." The treating doctor subsequently referred the claimant to Dr. R who then became the claimant's treating doctor. Dr. R in a report dated September 17, 2003, had an impression of bilateral lumbar radiculopathy and recommended further testing. Subsequent reports dated November 12 and December 5, 2003 and January 12, 2004, had impressions of right lumbar radiculopathy and 2 mm central protrusion at L5-S1. Dr. R performed a lumbar facet injection on December 5, 2003, which apparently was "of little to no benefit." (Dr. MC's report of February 26, 2004). The hearing officer again in the Background Information section, incorrectly identifies Dr. M as the designated doctor.

Dr. MC was the designated doctor and in a report dated February 26, 2004, certified that the claimant was not at MMI and estimated that the claimant would reach MMI "on or about 6/1/04." In evidence are surveillance videotapes of the claimant performing activities in January 2004 and on March 18, 19, and 23, 2004. The hearing

[1] We do note that both Dr. M, on a Report of Medical Evaluation (TWCC-69) and narrative, and Dr. MC on a TWCC-69 form, refer to themselves as the designated doctor.

officer describes the videos, particularly the March 18 through 23, 2004 ones, in some detail in the Background Information section of his decision. The claimant was subsequently examined by Dr. M, the carrier's RME doctor, on May 11, 2004. Dr. M found inappropriate reaction to Waddell testing, diagnosed a "Probable lumbar strain superimposed on preexisting spondylosis without evidence of radiculopathy" and certified the claimant at clinical MMI on May 11, 2004, with a 5% IR based on Diagnosis-Related Estimates (DRE) Lumbosacral Category II: Minor Impairment of the Guides to the Evaluation of Permanent Impairment, fourth edition (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the American Medical Association prior to May 16, 2000).

Dr. R subsequently referred the claimant to (Dr. TM) who in turn put the claimant in the subclaimant's program. The claimant finished the program in December 2004 and Dr. TM, in a TWCC-69 and narrative dated March 17, 2005, certified the claimant at clinical MMI on December 9, 2004, with a 5% IR based on DRE Lumbosacral Category II: Minor Impairment. The 5% IR is not in dispute. The carrier contends that the MMI date is May 11, 2004, as assigned by Dr. M. The claimant contends that the MMI date is December 9, 2004, as assigned by Dr. TM.

EXTENT OF INJURY

An MRI performed in August 2003 identifies a 3 mm protrusion. Whether the claimant has a herniation and whether it was caused by the compensable incident is disputed. A Texas Department of Insurance, Division of Workers' Compensation (Division) Independent Medical Examination doctor in a June 1, 2004, report diagnoses a lumbar disc protrusion at L5-S1, lumbar facet syndrome and chronic L2 to S1 nerve root radiculopathy. Dr. TM in a report dated August 18, 2004, had diagnostic impressions which included chronic pain disorder. Dr. TM commented that the "patient is extremely inactive and inhibited in function." Dr. M in his May 12, 2004, report has a diagnosis of "Probable lumbar strain superimposed on preexisting lumbar spondylosis without evidence of radiculopathy." In his comments Dr. M notes "symptom magnification" and reiterates that the claimant "has no evidence of radiculopathy on any of his studies." Another doctor interprets the lumbar MRI as only showing multiple disc degeneration. The hearing officer finds that the claimed conditions did not arise out of the compensable injury, that the claimant's 2 mm disc protrusion was preexisting and "was not enhanced or accelerated by the work injury." There was conflicting evidence regarding the extent-of-injury issue and the hearing officer's decision as explained in the Background Information section is sufficiently supported by the evidence.

CARRIER WAIVER

Although the claimant generally appeals the waiver issue it appears that the principal thrust of the claimant's appeal is based on the fact that the carrier had preauthorized the subclaimant's program for treatment of chronic pain syndrome and that "fundamental fairness" required the carrier to accept the asserted injury and pay for treatment and travel for treatment of the claimed injury. On the purely carrier waiver

issue the hearing officer applied Appeals Panel Decision (APD) 051011, decided June 13, 2005 and APD 041738-s, decided September 8, 2004, in finding that the date of injury was prior to September 1, 2003, that the carrier had not disputed the claimed injury within seven days as required by Sections 409.021 and 409.022 and that the carrier had (written) notice of the claimed injury by July 30, 2003. The background discussion makes clear that the hearing officer believed, based on DRIS notes, that the carrier had received written notice of the injury on July 30, 2003, although Finding of Fact No. 7 erroneously states the "Carrier had notice of the claimed injury by August [*sic*] 30, 2003." The hearing officer then found that the seven day period to dispute pursuant to Section 409.021 would extend to August 6, 2003, and that it was not until August 18, 2003, that the claimant had the MRI which showed a disc protrusion/herniation. The hearing officer commented that "the Carrier would have no way to discover Claimant had the disc herniation at L5/S1 and lumbar radiculopathy/paresthesias until that date." The hearing officer concluded that the carrier did not waive the right to dispute compensability of the disc herniation at L5/S1 and lumbar radiculopathy/paresthesias. The hearing officer's determination on the carrier waiver issue is affirmed.

TRAVEL MILEAGE

The claimant claims reimbursement for travel mileage to receive treatment from Dr. R and the subclaimant. The hearing officer commented that because the "claimant was treated for diagnoses other than those within what are deemed compensable injuries, Claimant is not entitled to mileage reimbursement to [Dr. R's] office" or to the subclaimant. The carrier is only liable for mileage reimbursement when it becomes reasonably necessary for an injured employee to travel in order to obtain reasonable and necessary medical care for the compensable injury. Rule 134.6(a). Since the travel and treatment by the subclaimant was for the treatment of conditions found not to be compensable, the claimant is not entitled to reimbursement for those travel expenses. The hearing officer's determination on this issue is affirmed.

PREAUTHORIZATION AND FUNDAMENTAL FAIRNESS

The claimant and subclaimant contend that because the carrier preauthorized the chronic pain management treatment by Dr. R and the subclaimant, the carrier had accepted the alleged conditions as compensable. Rule 134.600(c) provides that the "carrier is not liable under subparagraphs (b)(1)(B) or (C) . . . if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury." We note that preauthorization for chronic pain management is required under Rule 134.600(h)(10) as opposed to voluntary certification of health care treatment and treatment plans under Rule 134.600(j) which do not require preauthorization. However, the voluntary certification under Rule 134.600(j)(3) does subject the carrier to liability even if there is a final adjudication that the injury is not compensable or was for a condition unrelated to the compensable injury. In APD 041658, decided August 31, 2004, the Appeals Panel held that it did not find merit in a subclaimant's assertion that the preauthorization compels a

finding that the claimed injury was part of a compensable injury by aggravation or otherwise.

Rule 134.600(f) provides in pertinent part that the carrier, shall approve or deny requests for preauthorization based solely upon the reasonable and necessary medical health care required to treat the injury, regardless of unresolved issues of compensability, extent of or relatedness to the compensable injury, or the carrier's liability for the injury. Rule 134.600(f)(5)(C) provides that the carrier shall include in the approval "notice of any unresolved denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury."

In evidence is a (PLN 11) form dated September 9, 2004, which indicated that the carrier was disputing medical benefits as well as indemnity benefits because "per [Dr. M's] evaluation of 5/11/04," there is "no need for continued treatment that relates to the above referenced claim" and that the carrier "accepts a sprain/strain only to the lumbar spine." The claimant's claim for reimbursement of travel expenses for medical treatment at the direction of Dr. R begins on September 17, 2004. There is no preauthorization document in evidence and the testimony appears to indicate that preauthorization was obtained in some manner and time from the carrier's adjuster. The hearing officer based his determination on this issue on the basis that the travel for treatment was for a noncompensable condition. From the evidence submitted we are unable to ascertain how the preauthorization was obtained and whether the preauthorization had the referenced Rule 134.600(f)(5)(C) notice. In any case there is no provision in Rule 134.600, or its preamble, which provides for a waiver (in cases where preauthorization is required) in the event the notice requirement of Rule 134.600(f)(b)(C) is not given. We decline to read such a provision into the rule. The hearing officer's decision on this issue is affirmed.

MMI

As previously noted a properly appointed designated doctor found the claimant not at MMI on February 26, 2004, and estimated that MMI would be reached on or about June 1, 2004. The carrier's RME doctor, Dr. M, certified the claimant at MMI on May 11, 2004. We note that the claimant was apparently never sent back to the designated doctor for reevaluation for MMI on or about June 1, 2004. Instead the claimant began a course of treatment with Dr. R, and the subclaimant until Dr. TM certified MMI on December 9, 2004. The hearing officer clearly, and incorrectly, stated that Dr. M was the designated doctor. Although the hearing officer found (Finding of Fact No. 12) that Dr. M's "assigned MMI date is supported by a preponderance of the evidence" the hearing officer erred in stating that Dr. M was the properly appointed designated doctor. By doing so the hearing officer may have accorded Dr. M's MMI date greater weight than it was entitled to.

We reverse the hearing officer's determination that the claimant reached MMI on May 11, 2004, as assigned by Dr. M, "the properly appointed designated doctor." We

remand the case back to the hearing officer for a determination on an MMI date applying the correct standard.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 92642, decided January 20, 1993.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

LEO F. MALO
12222 MERIT DRIVE, SUITE 700
DALLAS, TEXAS 75251-2237.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Robert W. Potts
Appeals Judge

_____
Margaret L. Turner
Appeals Judge